MEMORANDUM

TO: Health Care Providers

SUBJECT: Health Care Provider Agreement

Dear Health Care Provider:

Laws and regulations affecting the health care industry require the Indiana State Department of Health to utilize a Provider Agreement. Information is required to facilitate our business relationship with health care providers, which will enable us to serve and protect the people of Indiana covered by our various health programs.

The Department of Health sincerely appreciates your interest and looks forward to a mutually beneficial relationship. Please review and complete the attached Provider Agreement and return it to us within 30 days of the date of this mailing so that we can establish this professional relationship.

Please direct any questions to Provider Relations by calling 800-475-1355.

Indiana State Department of Health

Provider Agreement Packet

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Maintenance Forms & Instructions

Indiana State Department of Health
Provider Agreement

FREQUENTLY ASKED QUESTIONS

Will I have to complete a new Provider Agreement every year?

No, the new agreement is structured so that future changes should be able to be handled through an addendum.

What is taxonomy code?

The provider taxonomy is a code set that identifies a health care provider by type and specialty and is expected to take the place of specialty codes. A provider may have more than one taxonomy code depending on the type of service rendered. The taxonomy is a required data element on the 837 Institutional, 837 Professional, and 278 EDI transactions. The taxonomy code is not a UPIN, Medicare provider number, or Medicaid provider number. The following is an example of the taxonomy code of an FQHC:

FQHC – 261QF0400N

-26 Ambulatory Health Care Facility
-1Q Clinic/Center
-F0400 – Federally Qualified Health Center
-N – 'no' to national education requirement

Is it necessary to fill in both the taxonomy code and the specialty code?

No. You only need to provide either the taxonomy code or the specialty code, not both.

Can I bill on paper claim forms or must I sign the EDI Trading Partner Addendum and bill electronically?

Yes, you can bill on paper claim forms, if you wish. However, the Indiana State Department of Health can handle electronic claims & other electronic transactions and encourages you to use those capabilities.

Instruction Sheet

Please read carefully:

1. All Billing Providers are required to:
   - ❑ **Sign** the Provider Agreement
   - ❑ **Read** Schedule A
   - ❑ **Print your Provider # at the top of Page 1 of Schedule B**
   - ❑ **Complete** Schedules B and C
   - ❑ **Complete** applicable addendums
   - ❑ **Complete** the CSHCS Acknowledgement of Participation Addendum
   - ❑ **Are not expected to,** but may complete the Maximum Case Load Addendum
   - ❑ **Provide** a copy of their License/Registration/Certification
   - ❑ **Complete** a "Taxpayer Identification Number and Certification" W-9 form

2. A Group Provider is a Billing Provider consisting of more than one individual. Group Providers must also complete & submit the form **"Individuals Covered Under Provider Agreement"**, plus all individuals listed on the above form are required to:
   - ❑ **Complete** a separate Provider Agreement (the three page Agreement)
   - ❑ **Provide** a copy of their License/Registration/Certification.

3. Billing Providers who wish to bill on **Paper Claim** forms must use the following forms & version (if noted):
   - ❑ **CMS-1500 (12-90)**
   - ❑ **CMS-1450 (UB92)**
   - ❑ **American Dental Association (Version 2000)**
   - ❑ Indiana Family and Social Services Administration **Drug Claim Form** (most recent version)
   - ❑ Indiana Family and Social Services Administration **Compound Prescription Drug Claim Form** (most recent version)

4. Billing Providers who wish to participate in Electronic Data Interchange (**EDI**) must:

   - ❑ **Complete** the EDI Trading Partner Addendum
   - ❑ **Complete** the EDI Enrollment Form

<u>Mailing Instructions</u>:
Completed Agreement
Completed applicable Addendums
Completed "Taxpayer Identification Number and Certification" (W-9)
Copy of your License/Registration/Certification
Completed form "Individuals Covered Under Provider Agreement"
should be forwarded to:

Indiana State Department of Health
Provider Relations – 7B
2 North Meridian
Indianapolis, IN 46204

All providers will be notified in writing of their enrollment status.

*Attached to the packet of information you received are "**Provider Update**" and "**Change of Ownership**" forms for your use to report **future** changes in addresses, tax information and certification/licensure.

PROVIDER AGREEMENT

State Form 51396 (7-03)
Indiana State Department of Health

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a Provider in Indiana State Department of Health (ISDH) Programs. As an enrolled Provider in ISDH Programs, the undersigned entity agrees to provide ISDH Program-covered services and/or supplies to ISDH participants. As a condition of enrollment, Provider agrees to the following:

1. To comply with all federal and state statutes and regulations pertaining to ISDH Programs, as they may be amended from time to time.

2. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements.

3. To notify ISDH within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.

4. To give written notice to ISDH by completion of "Billing Provider Update Form", at least sixty (60) days before the effective date of the change for any of the following: name (legal name), DBA (doing business as), name as registered with the Secretary of State, address (service location), pay to, mail to, or home office address, Federal tax ID number(s), or change in providers direct or indirect ownership, interest or controlling interest.

5. To provide ISDH Program-covered services and/or supplies pursuant to all applicable Federal and State statutes and regulations.

6. To safeguard information about ISDH Program participants including at a minimum:

a. name, address, and social and economic circumstances;
b. medical services provided;
c. medical data, including diagnosis and past history of disease or disability;
d. any information received in connection with the identification of legally liable third party resources.

7. To release information about ISDH Program participants only to the ISDH, only when in connection with payment issues surrounding providing services for participants.

8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility to assure that all activities under this contract are carried out.

9. To submit claims for services rendered by the Provider or employees of the provider and not to submit claims for services rendered by contractors unless the Provider is a health care facility (such as hospital, ICF-MR, or nursing home), or a government agency with a contract that meets the requirements described in Item 8 of this Agreement. Health care facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide ISDH Program services rendered pursuant to this Agreement.

10. To abide by the ISDH Program Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the ISDH Program Provider Manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with ISDH.

11. To submit timely billing in arrears on ISDH approved claim forms or electronically via Electronic Data Interchange (EDI), as outlined in the ISDH Program Provider Manual, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

12. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

13. To submit claim(s) for ISDH reimbursement only after first exhausting all other sources of reimbursement as required by the ISDH Provider Manual, bulletins, and banner pages.

14. To submit claim(s) for ISDH reimbursement utilizing the appropriate claim forms and codes as specified in the ISDH Provider Manual, bulletins and notices.

15. To submit claims that can be documented by Provider as being strictly for:

a. medically necessary medical assistance services;
b. medical assistance services actually provided to the person in whose name the claim is being made; and
c. compensation that Provider is legally entitled to receive.

16. To accept payment as payment in full, the amounts determined by ISDH as the appropriate payment, for ISDH Program covered services provided to ISDH Program participants. Provider agrees not to bill participants, or any member of a participant's family, for any additional charge for ISDH Program covered services.

17. The Provider hereby agrees to remove from collections any participant that has been wrongfully identified as delinquent within 5 business days of notice from ISDH.

18. To refund within fifteen (15) days of receipt, to ISDH any duplicate or erroneous payment received.

19. To make repayments to ISDH, or arrange to have future payments from the ISDH withheld, within sixty (60) days of receipt of notice from ISDH that an investigation or audit has determined that an overpayment to Provider has been made. A hospital licensed under *IC 16-21* has one hundred eighty (180) days to repay.

20. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

21. Obtain Prior Authorization for certain designated services for participants of various Programs of the ISDH. Failure to obtain a Prior Authorization, when required, will result in denial of payment and the participant/family may not be billed for the unauthorized services. A Prior Authorization confirms medical necessity and its relationship to an eligible medical diagnosis, but is not a guarantee of payment. Non-emergency designated services should not be provided until Prior Authorization approval is received from ISDH. Charges for services provided while their Prior Authorization determination is pending, will be the provider responsibility, in the event that authorization is denied by ISDH**.**

22. To cease any conduct that ISDH or its representative deems to be abusive of the ISDH Program.

23. To promptly correct deficiencies in Provider's operations upon request by ISDH.

24 .To cooperate with ISDH or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

25. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex, religion or sexual orientation, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of a ISDH Program-covered service.

26. To abide by and agree to the terms and conditions set out in Schedule A (Certification Statement for Providers Submitting Claims), which is incorporated herein by reference.

27. To furnish to ISDH or its agent, as a prerequisite to the effectiveness of this Agreement, the information set out in Schedules B and C to this Agreement, which are incorporated herein by reference, and to update this information, when it changes.

28. To abide by and agree to the terms and conditions set out in the various addenda applicable to the ISDH Programs, with which the provider participates, which are incorporated herein by reference.

29. That this Agreement may be terminated as follows:

a. By ISDH for Provider's breach of any provision of this Agreement as determined by ISDH; or
b. By ISDH, or by Provider, upon thirty day (30) written notice.

30. That this Agreement has not been altered, and upon execution by provider & approval by ISDH, supersedes and replaces any Provider Agreement previously executed with ISDH, by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, HEREBY AGREES, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

FURTHER, THE UNDERSIGNED HEREBY BINDS ALL SUCCESSORS, ASSOCIATES AND ASSIGNEES TO THE STIPULATIONS SET FORTH IN THIS AGREEMENT.

Provider-Authorized Signature – All Schedules

NOTE - The owner or an authorized officer of the business entity must complete this section.

I certify, under penalty of law, that the information stated in Schedules B and C is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified, I may be considered for suspension from the program and/or prosecution for Fraud. I hereby authorize the Indiana State Department of Health to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana State Department of Health Programs.

Provider DBA Name_____

Officer Name _____ Title _____

Signature _____ Date _____

Telephone Number _____

NOTE: Failure to complete this section will result in ISDH returning the application for incomplete information.

Provider Agreement – Schedule A

Indiana State Department of Health

Certification Statement for Providers Submitting Claims

This is to certify that any and all information contained on any Indiana State Department of Health (ISDH) billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (i. e. either by myself, my staff, and/or a third party acting in my behalf, such as a service bureau). I fully recognize that any billing intermediary, or service bureau that submits billings to the ISDH is acting as my representative and not that of ISDH. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for purposes of submission of ISDH claims.

I understand that payment and satisfaction of any claims that shall be submitted on my behalf will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable federal and/or state law. The provider will hold harmless and indemnify ISDH from any and all claims, actions, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses, which arise out of or are alleged to have arisen out of or as a consequence of the submission of ISDH billings by the provider through electronic, telephonic, mechanical, and/or standard paper means of submission unless the same shall have been caused by negligent acts or omissions of ISDH.

I acknowledge that the fees and charges paid to providers for all medical services rendered or materials supplied shall be in accordance with federal and state law and regulation with recognition of the provider's traditional right to charge for services rendered. I hereby certify that the charges submitted upon my claims shall be my usual and customary charges for my services with recognition of the provider's traditional right to charge for his services. I am aware of the restricted funding of ISDH Programs, and I agree to accept as full payment for any services billed on any claims, the payment allowance determined by the ISDH.

I further certify that no supplemental charges will be billed to any ISDH Programs member or to the family of any member for any covered service of the ISDH Programs.

I agree to keep such records as may be necessary to fully disclose the extent of services provided to individuals under the ISDH Programs, and to furnish such information regarding any ISDH payments claimed for providing such services to ISDH or its designee, upon request, for a period not less than three years from the date of service, or any such period ISDH may require. In those cases when information substitutes are allowed, I further acknowledge that I will maintain all required supporting claim documentation in my place of business and make such documentation available for review by ISDH. I agree to keep records independent of any paper claims, tapes, telephonic submission, or other electronic media that have been sent to ISDH for claims payment, to document the accuracy of the service for which I have billed the ISDH Programs. I agree to submit such records as may be required by ISDH or the federal government.

I agree to notify ISDH of any changes in my provider name or address. Further, I agree to comply with such minimum substantive and procedural requirements for claims submission, as may be required by ISDH.

I understand that the standard paper claim form may include a signature line. I understand that all of the stipulations, conditions, and terms of the certification statement apply in the event that I fail, for any reason, to sign the paper claim and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature, in no way absolves me of the terms stated herein to which I have agreed.

Provider Agreement – Schedule B
State Form 51452 (7-03)
Indiana State Department of Health

Billing Provider Enrollment Application

Provider Information

1. Provider Type and Specialty

Please complete the information about your licensure as determined and maintained by the official licensing board for your provider type and. specialty. **Refer to ISDH Billing Provider Specialty List to determine the provider type and specialty numbers for your primary and secondary specialty**. **Taxonomy Codes:** (When mandated.)

Provider Type _____ _____

Primary Specialty _____ _____

Secondary Specialty _____ _____

Primary Sub-Specialty _____ _____

Secondary Sub-Specialty _____ _____

NOTE: You may select only one provider type. If you want to enroll more than one provider type, a separate application must be completed for each provider type. Primary and secondary specialties must be listed under the same provider type on the Billing Provider Specialty List.

2. Which of the following best describes this service location?

Please indicate the choice that best describes the provider location being enrolled. Only one choice may be checked.

__ Individual Practice __ Group Practice __ Facility or Organization Other _____

Note: For Provider Agreements covering more than one individual, please complete the attachment "Individuals Covered Under Provider Agreement".

3. Locality

Please check the locality that best describes the service location. Please check **only one** item.

__ Metropolitan __ Rural __ Urban

4. Service Location Name and Address

Please complete the Provider Name, DBA Name, County, Telephone Number, Address, and the nine-digit ZIP Code for the site where services will be performed. You must complete a separate application for each location where services are performed, even if you bill claims from all locations under one provider number. Except for Sole proprietors who are registered with the County Recorder or use his or her own legal names for business purposes, each service location name must be the Doing Business As (DBA) name registered with the Secretary of State. The address must be a physical location. A post office box is not a valid service location address.

Are you registered with the Secretary of State? __ Yes __ No

Provider Name: _____ County: _____

DBA Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

5. Legal Name and Home Office Address

Please complete the contact information for the home office of the legal entity maintaining ownership of this service location. The legal name must be the current name on tax, corporation, and other legal documents, and currently registered with the Secretary of State. The address must be a physical location. A post office box is not a valid home office address. If there is more than one legal name currently used by this business entity, attach an explanation listing each name, address, and tax ID number.

Legal Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

6. Mailing Name and Address

Please complete the information for the addressing of bulletins, provider manual updates, and general correspondence, **if different from the Service Location information**. A post office box is acceptable for a mailing address.

Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

7. Pay To Name and Address

Please complete the information for the addressing of checks, remittance advices, and general claims payment information, **if different from the Service Location information**. A post office box is acceptable for this address.

Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

8. Billing Agent

(If you would have us contact your Billing Agent with questions concerning billing issues, please provide the following information.)

Name: _____

Street Address: _____

City: _____ State _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

9. **Federal Tax Identification Number:** _____ Effective Date: _____

Important: Sections 10-14 require copies of the following documents for verification, as applicable.

- ❑ **Practitioner License from Licensing Board**
- ❑ **Clinical Laboratory Improvement Amendment (CLIA) Certificate**
- ❑ **Federal Drug Enforcement Administration (DEA) Certificate**
- ❑ **Medicare Provider Number Assignment Letter for Medicare Participation**

10. License/Registration/Certification

License/Registration/Certification Number: _____ Issuing Board: _____

Effective Date: _____ Expiration Date: _____

NOTE: A copy of the license from the appropriate licensing board must be attached to the application. Failure to attach a copy of the license will result in ISDH returning this application for incomplete information.

11. CLIA Certification

Please complete this section with the information from your Clinical Laboratory Improvement Amendment (CLIA) Certificate.

Certification Type:

CLIA Number: _____ __ Waiver

Effective Date: _____ _____ __ Provider-Performed Microscopy Procedure (PPMP)

Expiration Date: _____ __ Registration

__ Compliance

__ Accreditation

NOTE: A Copy of the certificate must be attached to the application. Failure to attach a copy of the certificate will result in denied claims for laboratory services.

12. Federal DEA Certification

Please complete this section with the information from your Federal Drug Enforcement Administration (DEA) Certificate.

DEA Number: _____

Effective Date: _____ Expiration Date: _____

NOTE: A copy of the certificate must be attached to the application. Failure to attach a copy of the certificate will result in denied claims for prescriptions you prescribe.

13. Medicaid Participation

Indiana Medicaid Number: _____ Effective Date: _____

14. Medicare Participation

Please complete the appropriate Medicare identification numbers.

Medicare Number: _____ Medicare Number State: _____

Universal Provider Identification Number (UPIN): _____

DME Supplier Number: _____

NOTE: A copy of the Medicare Number assignment letter (or Medicare Remittance Advice with correct Medicare number) must be attached to the application.

Billing Provider Enrollment Application

Ownership Information

1. How is this provider entity legally organized and structured?

Check the entity type that best describes the structure of the enrolling provider entity. Please check **only one** item..

__ For Profit Corporation __ Partnership __ Sole Proprietorship

__ Not-for-Profit Corporation __ Government Owned

2. Is this entity chain affiliated?

If yes, the information regarding the chain must be included in **Item 4** below.

__ Yes __ No

3. Is this entity operated by a management company, or leased in whole or part by another Organization?

__ Yes __ No

4. List all owners and officers of the business entity

List below the Name, Title, Social Security Number, and Address of each Officer, owner, and / or trustee of the provider entity, and the Name, Tax ID (TIN), and Address of any organization, corporation, or entity having direct or indirect ownership or controlling interest in the provider entity. Attach additional pages as necessary to list all officers, owners, management and ownership entities.

Name	Tax ID Number	Address
Relationship or Title		City, State, Zip + 4

Name	Tax ID Number	Address
Relationship or Title		City, State, Zip + 4

Name	Tax ID Number	Address
Relationship or Title		City, State, Zip + 4

5. Has there been a change in **ownership or control within the past year, or is a change of ownership anticipated?**

If yes, you must submit the enclosed CHANGE OF OWNERSHIP ADDENDUM form for the current provider entity, and a new application for the new ownership entity.

__ Yes __ No

6. Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year?

__ Yes __ No If yes, when? _____

7. Background Information

Has any agent, managing employee, or owner of the provider entity been excluded from or convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX or ISDH program since the inception of those programs?

__ Yes __ No

If **yes,** state below the Name, SSN, and position within the provider entity:

_____

_____

_____

_____

_____

Billing Provider Specialty List

Please review the list to find the primary and secondary specialty that best describes the service location being enrolled and record the specialty numbers in the appropriate fields in Schedule A, item 7.

Note: A secondary specialty may be designated only if it is included in the same provider type as the primary specialty.

If you are an **INTERNIST** or **PEDIATRICIAN,** please also record your applicable subspecialty from the list in the space provided. If you do not have a subspecialty in these two categories, please choose **GENERAL INTERNIST (Specialty 344)** or **GENERAL PEDIATRICIAN (Specialty 345).**

Provider Type	**Provider Specialty**
01 Hospital	010 Acute Care Hospital 011 Psychiatric Hospital 012 Rehabilitation Hospital
02 Ambulatory Surgical Center	020 Ambulatory Surgical Center
03 Extended Care Center	030 Nursing Home/Nursing Facility 031 Intermediate Care Facility for the Mentally Retarded (ICF/MR) 032 Pediatric Nursing Facility 033 Group Home/Residential Care Facility
04 Rehabilitation Facility	040 Rehabilitation Facility
05 Home Health Agency	050 Home Health Agency
06 Hospice	060 Hospice Agency
08 Clinic	080 Federally Qualified Health Clinic (FQHC) 081 Rural Health Clinic (RHC) 082 Medical Clinic 083 Family Planning Clinic 084 Nurse Practitioner Clinic 085 Title V Clinic 086 Dental Clinic 087 Therapy Clinic
09 Advanced Practice Nurse	090 Pediatric Nurse Practitioner 091 Obstetric Nurse Practitioner 092 Family Nurse Practitioner 093 Nurse Practitioner (Other) 094 Certified Registered Nurse Anesthetist (CRNA) 095 Certified Nurse Midwife
10 Mid-Level Practitioner	100 Physician Assistant 101 Anesthesiology Assistant

Provider Type	**Provider Specialty**
11 Mental Health Provider	110 Out Patient Mental Health Clinic 111 Community Mental Health Center 112 Psychologist 113 Certified Psychologist 114 Health Service Provider in Psychology (HSPP) 115 Master of Social Work (MSW) 116 Clinical Social Worker 117 Psychiatric Nurse
12 School Corporation	120 School Corporation
13 Public Health Agency	130 County Health Department
14 Podiatrist	140 Podiatrist
15 Chiropractor	150 Chiropractor
16 Nurse	160 Registered Nurse (RN) 161 Licensed Practical Nurse (LPN) 162 Registered Nurse Clinical (RNC)
17 Therapist	170 Physical Therapist 171 Occupational Therapist 172 Respiratory Therapist 173 Speech/Hearing Therapist
18 Optometrist	180 Optometrist
19 Optician	190 Optician
20 Audiologist	200 Audiologist
21 Case Manager	210 Care Coordinator for Pregnant Women 211 HIV Case Manager 213 Targeted Case Manager
22 Hearing Aid Dealer	220 Hearing Aid Dealer
23 Dietitian	230 Registered Dietitian
24 Pharmacy	240 Pharmacy
25 DME/Medical Supply Dealer	250 DME/Medical Supply Dealer
26 Transportation Provider	260 Ambulance 261 Air Ambulance 262 Bus 263 Taxi 264 Common Carrier (Ambulatory) 265 Common Carrier (Non-Ambulatory) 266 Family Member
27 Dentist	270 Endodontist 271 General Dentistry Practitioner 272 Oral Surgeon 273 Orthodontist

Provider Type	Provider Specialty
27 Dentist (continued)	274 Pediatric Dentist 275 Periodontist 276 Mobile Dental Van 277 Prosthesis
28 Laboratory	280 Independent Laboratory 281 Mobile Laboratory
9 Radiology Provider	290 Freestanding X-Ray Clinic 291 Mobile X-Ray Clinic
30 End Stage Renal Disease Clinic	300 Freestanding Renal Dialysis Clinic
31 Physician	310 Allergist 311 Anesthesiologist 312 Cardiologist 313 Cardiovascular Surgeon 314 Dermatologist 315 Emergency Medicine Practitioner 316 Family Practitioner 317 Gastroenterologist 318 General Practitioner 319 General Surgeon 320 Geriatric Practitioner 321 Hand Surgeon 322 Internist (with Subspecialty) Subspecialty List: Adult Critical Care Medicine Adolescent Medicine 323 Neonatologist 324 Nephrologist 325 Neurological Surgeon 326 Neurologist 327 Nuclear Medicine Practitioner 328 OB/GYN 329 Hematologist/Oncologist 330 Opthalmologist 331 Orthopedic Surgeon 332 Otologist, Laryngologist, Rhinologist 333 Pathologist 334 Pediatric Surgeon 335 Pediatrician (with Subspecialty) Subspecialty List: Adolescent Medicine Diagnostic Lab Immunology Developmental Pediatrics Medical Toxicology Neonatal-Perinatal Medicine Pediatric Allergy Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Dermatology Pediatric Emergency Medicine

Provider Type	**Provider Specialty**
31 Physician (continued)	335 Pediatrician (with Subspecialty) – (continued) Subspecialty List: Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Neurology Pediatric Otolaryngology Physical Medicine & Rehabilitation Pediatric Pulmonology Pediatric Rheumatology Pediatric Sports & Fitness Medicine Pediatric Urology 336 Physician Medicine & Rehab Practitioner 337 Plastic Surgeon 338 Proctologist 339 Psychiatrist 340 Pulmonary Disease Specialist 341 Radiologist 342 Thoracic Surgeon 343 Urologist 344 General Internist (without Subspecialty) 345 General Pediatrician (without Subspecialty)
32 Waiver Provider	350 Aged and Disabled Waiver 351 Autism Waiver 352 ICF/MR Waiver 353 OBRA Developmentally Disabled Waiver 354 Medically Fragile Children's Waiver 356 Traumatic Brain Injury Waiver
33 Other (Not otherwise classified)	

PROVIDER AGREEMENT - Individuals Covered Under Provider Agreement

State Form 51397 (7-03)
Indiana State Department of Health

Group Provider Name: ____

Effective Date	**Expiration Date**	**Provider Type**	
__________	__________	_____	**Provider Name:** ____
			Specialty: ____
__________	__________		**License/Registration/Certificate Number:** ____________________________
__________	__________		**Federal DEA Certificate Number:** ____________________________
__________	__________	_____	**Provider Name:** ____
			Specialty: ____
__________	__________		**License/Registration/Certificate Number:** ____________________________
__________	__________		**Federal DEA Certificate Number:** ____________________________
__________	__________	_____	**Provider Name:** ____
			Specialty: ____
__________	__________		**License/Registration/Certificate Number:** ____________________________
__________	__________		**Federal DEA Certificate Number:** ____________________________
__________	__________	_____	**Provider Name:** ____
			Specialty: ____
__________	__________		**License/Registration/Certificate Number:** ____________________________
__________	__________		**Federal DEA Certificate Number:** ____________________________
__________	__________	_____	**Provider Name:** ____
			Specialty: ____
__________	__________		**License/Registration/Certificate Number:** ____________________________
__________	__________		**Federal DEA Certificate Number:** ____________________________

Effective Date	Expiration Date	Provider Type	Individuals Covered Under Provider Agreement

______ ______ ____ **Provider Name:** ______________________________

Specialty: ______________________________

______ ______ **License/Registration/Certificate Number:** ____________________

______ ______ **Federal DEA Certificate Number:** ____________________

______ ______ ____ **Provider Name:** ______________________________

Specialty: ______________________________

______ ______ **License/Registration/Certificate Number:** ____________________

______ ______ **Federal DEA Certificate Number:** ____________________

______ ______ ____ **Provider Name:** ______________________________

Specialty: ______________________________

______ ______ **License/Registration/Certificate Number:** ____________________

______ ______ **Federal DEA Certificate Number:** ____________________

______ ______ ____ **Provider Name:** ______________________________

Specialty: ______________________________

______ ______ **License/Registration/Certificate Number:** ____________________

______ ______ **Federal DEA Certificate Number:** ____________________

______ ______ ____ **Provider Name:** ______________________________

Specialty: ______________________________

______ ______ **License/Registration/Certificate Number:** ____________________

______ ______ **Federal DEA Certificate Number:** ____________________

______ ______ ____ **Provider Name:** ______________________________

Specialty: ______________________________

______ ______ **License/Registration/Certificate Number:** ____________________

______ ______ **Federal DEA Certificate Number:** ____________________

PROVIDER AGREEMENT
Children's Special Health Care Services (CSHCS) Program Addendum
State Form 51398 (7-03)
Indiana State Department of Health

Acknowledgement of Participation

- Payment will be based upon the Medicaid rate, in accordance with state statutes and regulations. Payment as determined by the CSHCS Program shall be accepted as payment in full. Balances cannot be billed to the family.
- Authorization of emergency services must be requested within five (5) days of services being provided
- CSHCS must be billed for all services provided to participants and participant/family may not be billed directly.

Having elected to participate within the Children's Special Health Care Services (CSHCS) Program, I acknowledge the above addendum relating to the CSHCS Program.

Provider DBA Name_____ Tax ID _____

Officer Name _____ Title _____

Signature _____Date_____

PROVIDER AGREEMENT
Children's Special Health Care Services (CSHCS)
Maximum Caseload Addendum

State Form 51399 (7-03)
Indiana State Department of Health

I/We choose to accept no more than ____ active cases with the Children's Special Health Care Services Program, at this time.

Provider DBA Name _____

Officer Name _____ Title _____

Signature _____ Date _____

Telephone Number _____ ISDH Provider ID _____

Do not complete this form <u>unless</u> you wish to limit the number of patients you accept, which are participants in the Children's Special Health Care Services Program.

Electronic Data Interchange (EDI) Trading Partner Invitation

State Form 51400 (7-03)
Indiana State Department of Health

The Indiana State Department of Health (ISDH) is committed to conducting its business transactions with the health care provider community as efficiently as possible. Therefore, ISDH invites all participating providers to utilize Electronic Data Interchange (EDI), as is appropriate and practical. If you do not wish to conduct business electronically, please disregard the invitation.

In furtherance of that objective, an EDI Trading Partner Agreement and Profile are included for your review, execution, and return to ISDH. Only certain providers are required to become an Indiana State Department of Health (ISDH) trading partner. Please read the following descriptions to determine the scenario that best fits your situation. If appropriate, have your billing service or clearinghouse complete and return these forms on your behalf.

Providers who ARE required to become an ISDH Trading Partner:

Billing providers who exchange data electronically directly with ISDH using a software vendor must become an ISDH trading partner by completing the following two steps:

1. Complete an EDI Trading Partner Profile-Provider
2. Complete a Trading Partner agreement

Providers creating their own software to send or receive electronic transactions will be considered a software vendor and must test following the same testing and approval process as a software vendor.

Providers who are NOT required to become an ISDH Trading Partner:

Billing providers who exchange electronic data via a billing service or clearinghouse do NOT need to submit a trading partner agreement but will need to submit an EDI Trading Partner Profile-Provider. The billing service or clearinghouse is the trading partner and will need to submit an EDI Trading Partner Profile-Billing Service/Clearinghouse and Trading Partner Agreement.

Billing providers will still need to submit an EDI Trading Partner Profile-Provider as it contains information that is necessary for the process. Also, providers wanting to receive any outbound transactions via a billing service or clearinghouse, for example an 835-Remittance Advice, must send a completed EDI Trading Partner Profile-Provider form to the ISDH as authorization for the ISDH to release the provider's data to the billing service or clearinghouse.

If this scenario fits your situation, please follow the steps below:

1. Complete an EDI Trading Partner Profile-Provider and return it to the ISDH.
2. Forward the EDI Trading Partner Profile-Billing Service/Clearinghouse and the Trading Partner Agreement to your intermediary for them to complete.

Step 1. Complete an EDI Trading Partner Profile

The ISDH requires all providers exchanging electronic data directly or through an intermediary with the ISDH to complete and submit the EDI Trading Partner Profile. The EDI Trading Partner Profile is the tool the provider or its intermediary must use to notify the ISDH about the types of transactions they will exchange and the protocols they will use. After the initial setup, the EDI Trading Partner Profile - Provider Change Form will be used to inform the ISDH of any changes to their vendor software, billing service, or clearinghouse selection.

Step 2. Complete a Trading Partner Agreement

The trading partner agreement is a contract between parties who have chosen to become electronic business partners. The trading partner agreement stipulates the general terms and conditions under which the partners agree to exchange information electronically. If an entity is sending multiple transaction types electronically, only one signed trading partner agreement is required.

Billing providers using approved software products to exchange data directly with the ISDH are considered trading partners and must send a signed Trading Partner Agreement before they can send production submissions.

If a billing provider is submitting transactions through a clearinghouse or billing service, the clearinghouse or billing service is the trading partner and a trading partner agreement is not required from the individual provider. Please forward the enclosed EDI Trading Partner Profile – Billing Service / Clearinghouse form and Trading Partner Agreement – EDI to your intermediary for them to complete and return to the ISDH.

The completed document(s) must be signed and mailed to the following address:

ISDH
Office of HIPAA Compliance
EDI Provider Relations, 3K
2 North Meridian Street
Indianapolis, IN 46204-3010

Once the documents are received they will be evaluated for exchanging production data. The trading partner will receive written notification of approval. The written approval contains trading partner ID, login ID, password, and other communication information.

If you have any questions about these forms or about the process, please call 317-233-9803.

EDI will not be available for production submissions until October 16, 2003. Upon receipt of the Trading Partner Profile and Agreement, a member of the ISDH EDI staff will contact you concerning your EDI setup and testing.

Electronic Data Interchange (EDI) Trading Partner Profile - Provider

State Form 51401 (7-03)
Indiana State Department of Health

Provider of Service:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Software Vendor (please complete this section if you will be using software, either purchased or developed internally, to transmit transactions directly to ISDH):

_____ Purchased (please complete the information below) ____ Developed in-house (do not complete below)

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Data Transmission / Retrieval Method (please complete if you will be submitting transactions directly from your office to ISDH):

__ **Asynchronous** Dial-up

__ **FTP** via PPP Dial-up Connection

Billing Service, or Clearinghouse Information (please complete this section if you are using a billing service or clearinghouse to submit transactions to the ISDH. Please forward the enclosed Trading Partner Profile-Billing Service/Clearinghouse and Trading Partner Agreement to your intermediary for them to complete):

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Indicate your request(s) for the EDI transactions below.

Inbound (sent from you to ISDH):

__ Health Care Claim (837)
__ Prior Authorization (278)
__ Eligibility Request (270)
__ Claim Status Request (276)
__ Retail Pharmacy Prior Authorization (NCPDP)
__ Retail Pharmacy Claim (NCPDP)
__ Retail Pharmacy Eligibility Request (NCPDP)

Outbound (sent from ISDH to you):

__ Payment Advice (835)
__ Prior Authorization (278)
__ Eligibility Request (271)
__ Claim Status Request (277)
__ Retail Pharmacy Prior Authorization (NCPDP)
___Retail Pharmacy Eligibility Request (NCPDP)

Remittance Advices are provided on a weekly basis ONLY and include claims submitted electronically and on paper.

Outbound Transaction Transmission

All outbound transmissions indicated above will be sent to the provider of service. If you want outbound transactions to be sent via a clearinghouse or billing service, please initial below.

I am authorizing the outbound transactions indicated to be sent to my intermediary listed on page 1

_____
Provider's Initials

_____ _____
Authorized Signature Date

_____
Title of Authorized Signatory

Remittance Address:
ISDH
Office of HIPAA Compliance
EDI Provider Relations, 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803

Electronic Data Interchange (EDI) Trading Partner Profile - Billing Service/Clearinghouse

State Form 51441 (7-03)
Indiana State Department of Health

A provider of services has informed us that they would like to begin doing Electronic Data Interchange (EDI) transactions with the Indiana State Department of Health (ISDH). They have informed us that you are their Business Associate for their EDI transactions. Therefore, in order to begin the process, please complete this document and sign the EDI Trading Partner Agreement. Please return these documents to the address below. EDI will not be available for production submissions until October 16, 2003. Upon receipt of the Trading Partner Profile and Agreement, a member of the ISDH EDI staff will contact you concerning your EDI setup and testing. If you have already submitted a profile and an agreement to the ISDH you do not need to complete these forms again.

Billing Service / Clearinghouse:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Indicate your request(s) for the EDI transactions below.

Inbound (sent from you to ISDH):

__ Health Care Claim (837)
__ Prior Authorization (278)
__ Eligibility Request (270)
__ Claim Status Request (276)
__ Retail Pharmacy Prior Authorization (NCPDP)
__ Retail Pharmacy Claim (NCPDP)
__ Retail Pharmacy Eligibility Request (NCPDP)

Outbound (sent from ISDH to you):

__ Payment Advice (835)
__ Prior Authorization (278)
__ Eligibility Request (271)
__ Claim Status Request (277)
__ Retail Pharmacy Prior Authorization (NCPDP)
___Retail Pharmacy Eligibility Request (NCPDP)

Remittance Advices are provided on a weekly basis ONLY and include claims submitted electronically and on paper. Outbound transmissions will only be sent with prior authorization from billing provider.

Data Transmission / Retrieval Method

__ **Asynchronous** Dial-up

__ **FTP** via PPP Dial-up Connection

_____ _____
Authorized Signature Date

_____
Title of Authorized Signatory

Remittance Address:
ISDH
Office of HIPAA Compliance
EDI Provider Relations, 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803

TRADING PARTNER AGREEMENT - Electronic Data Interchange (EDI)

State Form 51402 (7-03)
Indiana State Department of Health

This document constitutes an agreement to the following provisions for exchanging Electronic Data Interchange (EDI) between the Trading Partner listed under the *Signatures* heading in this agreement and the Indiana State Department of Health (ISDH).

A. The Trading Partner agrees:

1. To conform to the requirements for *Administrative Simplification* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91),* and regulations promulgated there under and to take no action which adversely affects ISDH's HIPAA compliance.
2. That it will promptly notify ISDH of any and all unlawful or unauthorized disclosures of confidential information or protected health information (PHI) that comes to its attention and will cooperate with ISDH in the event any litigation arises concerning the unauthorized use, transfer, or disclosure of either confidential or protected health information.
3. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.
4. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, effective on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*
5. That it will establish and maintain procedures and controls so that information concerning ISDH health plan participants, or any information obtained from ISDH, shall not be used by agents, officers, or employees of the trading partner other than for its sole intended purpose.
6. That the information stated in any EDI Trading Partner Profile(s) submitted with this Agreement, or subsequently is correct and complete.
7. That it will allow ISDH 30 days after receipt of written notice from the provider if there is any change in the trading partner representative or location where electronic transactions are sent.
8. That it is bound by written agreement with the provider to comply with state and federal law, if the trading partner is an intermediary for the billing provider.

B. ISDH agrees:

1. To conform to the requirements for *Administrative Simplification* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91),* and regulations promulgated there under and to take no action which adversely affects the trading partner's HIPAA compliance.
2. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.
3. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, effective on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*

C. Both parties agree:

1. That documents will not be considered as received and no responsibility assigned until accessible at the receiving party's computer.
2. That upon receiving any documents, to prepare and transmit a timely response or an acknowledgment of transaction receipt. If acceptance of a document is required, a document is not considered received until an acceptance acknowledgement is returned.
3. To notify the other party within a reasonable time frame if any transmitted data are received in an unintelligible or garbled form.
4. That each party will provide and maintain the equipment, software, services, and testing necessary to transmit and receive documents.
5. To conduct business and perform as required by this agreement and any applicable rules or regulations.
6. That this agreement will remain in effect until terminated by either party with at least 30 days prior written notice. The notice will specify the effective date of termination, but will not affect the obligations or rights of either party prior to the effective date of termination. This agreement is automatically terminated in the event the trading partner or provider is disqualified through a federal administrative action or state action. That any document transmitted according to this agreement will be considered an original and signed when received electronically. Neither party will contest the validity or enforceability of signed documents under any applicable law concerning whether certain agreements must be signed in writing to be binding. Neither party will contest the admissibility of copies of signed documents under the business records exception to the hearsay rule, the best evidence rule, or the basis that the signed documents were not originated in documentary form.
7. That neither party will be liable for any special, incidental, exemplary, or consequential damages resulting from any delay, omission, or error in the electronic transmission or receipt of any document, even if either party has been advised such damages are possible.
8. That both parties will attempt to resolve any issues relating to this agreement.

D. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

_____	_____
Trading Partner	Phone Number
_____	_____
Signature Completed by/ Title (Original Signature ONLY)	Address
_____	_____
Date	City /State/ZIP+4

PROVIDER AGREEMENT - Change of Ownership

State Form 51403 (7-03)
Indiana State Department of Health

If you have recently undergone or are undergoing a Change of Ownership, please complete this form and enclose a copy of the purchase agreement with your enrollment application.

Change of Ownership Type:

__ Acquisition __ Merger* __ Acquisition of Assets Only

Effective Date: _____

Provider Number Changing Ownership: _____

Provider Name Changing Ownership: _____

Provider Name Changing Ownership **Forwarding Address**:

_____

_____

Service Location Changing Ownership: _____

Old Tax ID: _____

New Tax ID: _____

If a Group Provider, members remaining under new ownership:

Provider Number	Provider Name
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

* **Mergers:** Please complete additional copies as needed for each group or practice merging into the new Tax ID.

If your Legal Name, Mailing Address or Tax ID have changed:

A copy of a completed federal W-9 Form must be attached to this update form. Failure to attach the W-9 form will result in ISDH returning the documents you submitted.

Provider Agreement - Billing Provider Update Form Instructions

Indiana State Department of Health

For Groups, Facilities, and Sole Practitioners

General Instructions

Please read carefully

- This form is to be used for updating billing provider information as follows:

  Address Change (Service Location, Mailing, Payment, and Home Office)

  Re-certification

  Tax ID

  Clinical Laboratory Improvement Amendment (CLIA Certification)

  Drug Enforcement Administration (DEA) Certification

  Voluntary termination

- **Please do not use this form for g*roup* member updates, or changes of ownership.**
- If you are enrolling a new service location, adding a non-enrolled group member, or are undergoing a change in ownership, it will be necessary to complete a new **Provider Enrollment Application**.

Please complete only the sections that pertain to updated information for the Provider Number and Service Location listed. Each section includes some instructions on proper completion. Please read the instructions carefully. Many of the updates require documentation to be attached, so please be sure to include a copy of the necessary documents with the form.

Mailing Instructions:

Once you have fully completed the form and enclosed copies of all required licenses, forms, and certifications, please send the entire packet to:

ISDH - 2 North Meridian Street, Provider Relations - 7B, Indianapolis, IN 46204-3021

You will be notified in writing by ISDH regarding the status of your update once your service location update has been reviewed. Please allow I5 business days for mailing and processing time.

Questions:

Please contact ISDH Provider Relations by calling 800-475-1355, with any questions regarding these forms.

PROVIDER AGREEMENT – Billing Provider Update

State Form 51404 (7-03)
Indiana State Department of Health

For Groups, Facilities, and Sole Practitioners

Provider Information

NOTE: Updates will be made to the service location specified.

Provider Number _____ Service Location _____

Provider Name: _____

Taxpayer Identification Number: _____

Contact Name: _____ Telephone Number: _____

Complete only the sections that reflect a change to your provider information.

If Your Legal Name, Mailing Address or Tax ID have changed:

A copy of a completed federal W-9 Form must be attached to this update form. Failure to attach the W-9 form will result in ISDH returning the documents you submitted with a request for the W-9 form**.**

Address Information Update? ___**Yes**

---

1. Service Location Name and Address

Please complete the Name, County, DBA Name, Telephone Number, Street Address, City, State, and nine-digit ZIP code for the actual site where services are performed. The address must be a physical location. A post office box is not a valid service location address. The Service Location name is the Doing Business As (DBA) Name for each location.

NOTE: You must complete an update form for each service location address change.

Provider Name: _____ County: _____

DBA Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____Telephone: _____Ext: _____ Fax:_____

E-Mail Address: _____Effective Date: _____

2. Legal Name and Home Office Address

Please complete the contact information for the home office of the legal entity who has ownership of the above service location. The legal name must be the current name registered with the Secretary of State. This name will appear on corporate, tax, and other legal documents. If more than one legal name is currently used by this business entity, attach an explanation listing each name. The address must be a physical location. A post office box is not a valid home office address.

Legal Name: _____

Street Address: _____

City: _____State: _____ Zip + 4 _____

Contact Person: _____Telephone: _____Ext._____ Fax:_____

E-Mail Address: _____ Effective Date: _____

3. Mailing Name and Address

Please complete the contact information for addressing bulletins, provider manual updates, and general correspondence, **if different from the Service Location Address.** A post office box is an acceptable mailing address.

Name _____

Street Address _____

City _____ State _____ Zip + 4 _____

Contact Person _____Telephone _____ Ext. _____ Fax: _____

E-mail Address _____ Effective Date _____

4. Pay To Name and Address

Please complete the contact information for addressing checks, remittance advices, and general claims payment information, **if different from the Service Location Address**.

Name _____

Street Address: _____

City _____ State _____ Zip + 4 _____

Contact Person _____Telephone _____Ext. _____ Fax _____

E-mail Address _____ Effective Date _____

5. Billing Agent Name and Address

Please complete the contact information for addressing checks, remittance advices, and general claims payment information, **if different from the Pay To Address, or if none, the Service Location Address.**.

Name _____

Street Address _____

City _____State _____ Zip + 4 _____

Contact Person _____Telephone _____Ext. _____Fax _____

E-mail Address _____ Effective Date _____

Important. Sections 6-10 require copies of the following documents for verification as applicable.

- ❑ Completed Current Federal W-9 Form
- ❑ Practitioner License from Licensing Board
- ❑ Clinical Laboratory Improvement Amendment (CLIA) Certificate
- ❑ Federal Drug Enforcement Administration (DEA) Certificate
- ❑ Medicare Provider Number Assignment Letter

6. Federal Tax Information Update? ___ Yes Effective Date _____

Please complete this field with your federal Taxpayer Identification Number (TIN) if you are undergoing or have recently undergone a TIN change. If you are undergoing or have recently undergone a change of ownership, then you must complete a Billing Provider Enrollment Application for each service location changing ownership.

Taxpayer Identification Number _____

Have you undergone a change of ownership**?** ___Yes ___ No

Is the new tax ID the tax ID of a Practice Management Company? ___ Yes ___ No

NOTE: If you answered yes to either question, you must complete a Billing Provider Enrollment Application for each service location affected by the change in ownership or practice management. You must hold all claims until you receive confirmation of your new provider number(s) and service location.

7. Provider Specialty & Licensure Information Update? ___ Yes

Please complete the information about your licensure and your specialty. Please refer to the ISDH Provider Specialty List to determine the specialty numbers for your primary specialties. Primary and secondary specialties must be from the same provider type.

Add an additional Specialty _____ Remove a Specialty _____

Change Primary Specialty _____ Change Secondary Specialty _____

License/Registration/Certification Number _____

Effective Date _____ Expiration Date _____

NOTE: A copy of the license from the appropriate licensing board / agency must be attached to this form. Failure to attach a copy of the license will result in ISDH returning the documents you submitted with a request for the missing information.

8. Clinical Laboratory Improvement Amendment (CLIA) Certification Update? ___Yes

Please complete this section with the information from your (CLIA) Certificate.

NOTE: A copy of the certificate must be attached with this form. Failure to attach a copy of the certificate will result in denied claims for laboratory services.

CLIA Number _____ Certification Type _____

Effective Date _____ Expiration Date _____

9. Federal DEA Certification Update? ___Yes

Please complete this section with the information from your Federal Drug Enforcement Administration (DEA) Certificate.

NOTE: A copy of the certificate must be attached with this form. Failure to attach a **copy of the certificate will result in denied claims for prescriptions you prescribe.**

DEA Number _____

Effective Date _____ Expiration Date _____

10. Medicare Participation Update ___Yes

Please complete the appropriate federal Identification Numbers.

Medicare Number _____Medicare Number State _____

Universal Provider Identification Number (UPIN) _____

DME Supplier Number _____

11. Voluntary Termination Update? ___Yes

If you are voluntarily terminating your participation in one of the ISDH Programs, please complete the date of voluntary termination and the termination reasons in the field below. Please note that all locations specified in the Provider Information Section will be terminated. If no locations are specified, then the entire provider number will be terminated. It is understood that any participants on the CSHCS Program that are now assigned to the Provider will be reassigned to another Provider and no other participants from the CSHCS Program will be assigned. To resume participation in the CSHCS Program the Provider needs to contact the Indiana State Department of Health, Provider Relations.

Programs: _____

Termination Date: _____

Termination Reason: _____

12. Provider-Authorized Signature

I certify, under penalty of law, that the information stated on this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the program and/or prosecution for Fraud. I hereby authorize the Indiana State Department of Health to make all necessary verifications concerning me, and my practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my participation in the Indiana State Department of Health Programs.

Signature _____ Date _____

Name _____

Title _____Telephone Number _____

13. Comments Section

PROVIDER AGREEMENT – Group Provider - Member Update

State Form 51405 (7-03)
Indiana State Department of Health

Provider Name: _____

Provider Number: _____ Taxpayer Identification Number: _____

Contact Name: _____ Phone Number: _____

Return Address: _____

City, State, Zip code: _____

Please update the provider participation information for our group.

I certify, under penalty of law, that the information stated in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Indiana State Department of Health Programs and/or prosecution for Fraud. I hereby authorize the Indiana State Department of Health to make all necessary verifications concerning me, and this medical practice and further authorize and request each educational institution, medical/license board, or organization to provide all information that may be sought in connection with my/our participation in the Indiana State Department of Health Programs.

Group Provider Officer's Printed Name: _____

Officer's Title: _____

Officer's Signature: _____ Date:_____

Officer's Telephone Number: _____

Service Location Links

Group Provider - Member Update

Transaction Types: A = Add practitioner to service location
E = End-date practitioner from service location
U = Update information for practitioner at service location

Transaction Type	Effective Date	Expiration Date	Provider Type	
___	__________	__________	_____	**Provider Name:** ______________________________
				Specialty: ______________________________
	__________	__________		**License/Registration/Certificate Number:** ______________________
	__________	__________		**Federal DEA Certificate Number:** ______________________
___	__________	__________	_____	**Provider Name:** ______________________________
				Specialty: ______________________________
	__________	__________		**License/Registration/Certificate Number:** ______________________
	__________	__________		**Federal DEA Certificate Number:** ______________________
___	__________	__________	_____	**Provider Name:** ______________________________
				Specialty: ______________________________
	__________	__________		**License/Registration/Certificate Number:** ______________________
	__________	__________		**Federal DEA Certificate Number:** ______________________
___	__________	__________	_____	**Provider Name:** ______________________________
				Specialty: ______________________________
	__________	__________		**License/Registration/Certificate Number:** ______________________
	__________	__________		**Federal DEA Certificate Number:** ______________________
___	__________	__________	_____	**Provider Name:** ______________________________
				Specialty: ______________________________
	__________	__________		**License/Registration/Certificate Number:** ______________________
	__________	__________		**Federal DEA Certificate Number:** ______________________

Electronic Data Interchange (EDI) Trading Partner Profile – Provider Change

State Form 51406 (7-03)
Indiana State Department of Health

Provider of Service:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Change of Software Vendor:

____ Purchased (please complete the information below) ____ Developed in-house (do not complete below)

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Change of Billing Service or Clearinghouse Information:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Indicate your request(s) for the EDI transactions below.

Inbound (sent from you to ISDH):

___ Health Care Claim (837)
___ Prior Authorization (278)
___ Eligibility Request (270)
___ Claim Status Request (276)
___ Additional Patient Information (275)
___ Retail Pharmacy Prior Authorization (NCPDP)
___ Retail Pharmacy Claim (NCPDP)
___ Retail Pharmacy Eligibility Request (NCPDP)

Outbound (sent from ISDH to you):

___ Payment Advice (835)
___ Prior Authorization (278)
___ Eligibility Request (271)
___ Claim Status Request (277)
___ Retail Pharmacy Prior Authorization (NCPDP)
___Retail Pharmacy Eligibility Request (NCPDP)

Remittance Advices are provided on a weekly basis ONLY and include claims submitted electronically and on paper.

Data Transmission / Retrieval Method (please complete if you will be submitting transactions directly from your office to ISDH):

___ Asynchronous Dial-up

___ **FTP** via PPP Dial-up Connection

Outbound Transaction Transmission

All outbound transmissions indicated above will be sent to the provider of service. If you want outbound transactions to be sent via a clearinghouse or billing service, please initial below.

I am authorizing all outbound transactions be sent to my intermediary listed above _____
Provider's Initials

_____ _____

Authorized Signature Date

_____
Title of Authorized Signatory

Remittance Address:

ISDH
Office of HIPAA Compliance
EDI Provider Relations, 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803